ID #_____

FORM B

DIRECT MEDICAL COSTS FOR RABIES POST-EXPOSURE PROPHYLAXIS (PEP) TREATMENT

1. Type of medical facility where treatment administered:

____(1) County clinic
____(2) Emergency department
____(3) Private medical office
____(4) Urgent care
____(5) VA clinic
____(6) Other (describe_____)

2. Facility location (County): _____

3. Patient's gender: ( ) Male ( ) Female

4. Patient's date of birth (mm/dd/yy): _____/_____/_____

5. Patient's date of first rabies PEP treatment (mm/dd/yy):_____

6. Method of payment at time for rabies PEP treatment.

____(1) Self-pay
____(2) Private insurance
____(3) Workers' compensation
____(4) MediCal
____(5) Other (Specify:_____)

7. Direct medical costs. *List only costs directly related to the patient's rabies post-exposure prophylaxis treatment.

TOTAL DIRECT MEDICAL COSTS: $_____

Immunization	Date (mm/dd/yy)	$ Cost (HRIG/vaccine)	$ Cost (exam)	$ Cost (other*)
(a) HRIG				
(b) Vaccine 1				
(c) Vaccine 2				
(d) Vaccine 3				
(e) Vaccine 4				
(f) Vaccine 5				
(g) Additional vaccine or HRIG				

*Describe “other” direct costs:

_____
_____
_____